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No. 83-1262

In the Supreme Court of the United States

October Term, 1983

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, et al.,
Appellants,

vs.

FLORIDA PATIENT'S COMPENSATION FUND, et al.,
Appellees.

ON APPEAL FROM THE SUPREME COURT OF FLORIDA

BRIEF IN OPPOSITION TO APPELLEES' ALTERNATIVE MOTIONS TO DISMISS APPEAL OR TO AFFIRM JUDGMENT

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Appellants[1] file this brief in response to the Appellees' Alternative Motions to Dismiss Appeal or to Affirm Judgment Appealed.

I. Response to Arguments in Appellees' Point I - the Court Should Decide This Case on the Merits.

Although Appellees argue the same estoppel grounds they asserted below, it should be noted that the Florida Supreme Court did not decide this case on those grounds. Instead, the Florida Supreme Court interpreted the statute and then faced squarely the constitutional issues raised here. Those issues were decided erroneously, and this Court should review those issues on appeal.

1. The names, parents and subsidiaries of corporate appellants appear at A1 of the Jurisdictional Statement.

A. Joining in the Fund does not estop the hospitals from complaining of an unconstitutional interpretation or application of the Statute.

Appellees argue that the mere fact the Hospitals joined the fund estops them from contesting either the unconstitutional application or interpretation of the statute. Such a rule of law would produce absurd results. If that were the law, neither party to a contract could challenge the other's interpretation of it, and no person affected by a statute could complain that it was being unconstitutionally interpreted or applied.

It may be true, as appellees suggest, that the hospitals would have attempted to find other means of meeting their obligations of financial responsibility if they had known at the outset that the Insurance Commissioner and the Florida courts would interpret and apply the statute as they have. In fact, once the state's interpretation of the statute became known, all hospitals withdrew from the Fund. Nevertheless, they are left with approximately $190,000,000 of physician liability for the years that they were members of the Fund.

The reasons that the hospitals could not have anticipated the particular interpretation and application of the statute appealed from included the provisions of the statute that: (1) hospitals are to be a separate risk classification from doctors; (2) "fees" are to be set based on actuarial considerations, and (3) assessments are to fairly reflect the same classifications in the Statute, including the separate risk categories for hospitals. Appellees argue that the hospitals should have known from the beginning (and therefore voluntarily consented to) the State's interpretation which allowed actuarially inadequate fees for physicians, with the difference to be made up by hospitals through the assessment process. Such an interpreta-

tion renders the above provisions meaningless, and should not reasonably have been anticipated.

This is in no sense a case that can be summarily decided on the theory that the hospitals have previously waived their rights to protest the unconstitutionality of the statute as interpreted and applied. The Florida District Court of Appeal rejected Appellees' suggestion that the hospitals can be considered volunteers. It was not only the expense, but the unavailability in the marketplace of medical malpractice insurance, that prompted the creation of the Fund in the first place. The District Court held (Appendix to Jurisdictional Statement at 31) that the acceptance of the general benefits of an act does not estop a party to challenge the constitutionality of a separable portion thereof, such as the funding provisions here, and further held that the acceptance of benefits of an act under compulsion did not preclude an attack upon the Statute itself. The court specifically found that the exemptions from the compulsory membership provisions of the act were not realistic alternatives (*See* A31-32). Although the Appellees suggest that the Florida courts *could have* decided on purely state estoppel grounds, they did not. This Court should not assume an additional state court rationale, rejected by the Florida courts, in order to defeat its plain jurisdiction.

Appellees argue that this is a contract case, and that a Fund pamphlet and application form mentioned unlimited liability of hospitals for assessments. Their argument overlooks that fact that the statute is part and parcel of any contract,[2] and in any event, it is clear that constitutional

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2. E.g., *Mullis v. State Farm Mutual Automobile Insurance Co.*, 252 So.2d 229 (Fla. 1971); *Southeast Title & Insurance Co. v. Carrico*, 202 So.2d 179 (Fla. 1967); *Sellers v. United States Fidelity & Guaranty Co.*, 185 So.2d 689, 690 (Fla. 1966); ("[i]f the statute is to be meaningful and controlling . . ., all inconsistent clauses in the policy . . . must be judicially rejected").

rights are not waived by entering into contracts. For example, in *Sambo's Restaurants, Inc. v. City of Ann Arbor*, 663 F.2d 686 (6th Cir. 1981), a would-be Sambo's restaurant, responding to objections that the name "Sambo's" had racial overtones, agreed to use another name in return for a site plan approval. The restaurant owners later sought to use the name Sambo's by asserting their First Amendment rights to commercial speech, which the Sixth Circuit ruled were not waived by such an agreement. Here the hospitals have not waived their right to complain of an unconstitutional interpretation and application which eliminates the fundamental actuarial soundness requirement of the statute.

Appellees suggest that the hospitals are victims of a dilemma: That having entered into a contract incorporating an ambiguous statutory provision, the hospitals cannot complain of an unconstitutional interpretation or application of that statutory provision. Further, they suggest that the hospitals are attempting to rescind their contracts without offering to put the parties back in status quo. Contrary to Appellees' argument on page 9, this is not a rescission case. The hospitals are complaining here that the statute has been interpreted and applied in an unconstitutional manner, and they are entitled to relief from this Court on appeal.

B. Response to the suggestion that the hospitals contemplated subsidizing each other, therefore they cannot object to subsidizing physicians.

Appellees suggest on pages 9 and 10 of the motions that any kind of self-insurance involves spreading risks and argue that the hospitals therefore cannot object to paying physician losses. The argument ignores the language of the statute requiring separate risk categories for hospitals.

C. Response to factual assertions concerning fee setting.

Inaccurate factual assertions underlie Appellees' Arguments at pages 10-12 of their motion:

(1) It is contrary to the record that the Insurance Commissioner made a good faith effort to set fees or that base fees for prior years had proved adequate. Plainly, all monies generated by insurance premiums are not needed immediately to pay claims. The claims must first occur and be processed at least to the point of settlement. That is why cash deficiencies did not occur until the Fund had been in operation for several years, not because there was actuarial evidence that the "base fees" would be adequate without the "additional fees" required by the statute.

(2) The record will show that the Insurance Commissioner rejected the only actuarial information that he had before him, *not* that he made a good faith erroneous prediction on conflicting actuarial reports.

(3) There is no evidence that the unconstitutionality of the medical mediation panel provisions of the statute created the deficiencies in the Fund.

(4) It should not have been left to the Insurance Commissioner's sole discretion whether the fees should be increased—instead the statute required the Fund to report to the Insurance Commissioner on actuarially indicated rates and the Insurance Commissioner to take actuarial evidence and set actuarially sound fees.

(5) The representation that a hearing was held and that both physicians and hospitals argued that higher fees were not necessary is misleading and inaccurate. The record will show that in 1978 the Fund requested the In-

surance Commissioner to set higher physician fees (up to $12,000). The Commissioner did not do this, but rather charged all physicians only the $500.00 base fee. Although a hearing was held, the record will show that it was held in 1978 and that:

(a) The 1978 public hearing was announced as being "in the nature of a public fact finding inquiry" *not* a final hearing to resolve questions of interpretation of the statute under Florida's Administrative Procedures Act.

(b) The hospital representatives who were present, such as Atkins, testified *only as to hospital fees*, and spoke only for the proposed hospital rates, not physician rates,[3] thereby appropriately recognizing the statute's different "classifications." Atkins' testimony supported actuarially sound *hospital* rates. The arguments that the low *physician* rates were the result of *hospital* action is nowhere supported in the record.

(c) Although *some* representatives of *some* hospitals appeared at the public hearing involving the Fund's request for an actuarial increase for the 1978-1979 Fund year, they also complained of the insufficient notice to the individual members of the Fund (R 1367-1372), and the record is clear that all hospitals were neither represented nor notified.

(d) A fair reading of the 1978 order (R 1310) shows that the request for additional fees was denied because it was *premature*, there not having been sufficient experience with the Fund, and the Fund not being in danger

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3. "I speak only as this rate request applies to hospitals, because I have not studied the physician question." (Incidentally, it appears Mr. Atkins was correct in his position that the hospital fees at $300 per bed were actuarially sound. The deficits caused by hospital claims are insignificant.) (Respondent's Exhibit 10 at 42, R 1401.)

of immediate cash shortage. The conclusion of the 1978 order is that any change of existing fee structure "*is inappropriate at this time.*" The order is not titled as a final order and cannot fairly be construed as a "final agency action" interpreting of the statute as prohibiting actuarially sound fees for 1978 once more experience was gathered. The order contains no hint that four years later it would be construed as a "forever" final interpretation of the statute or an actuarial *setting* of fees rather than a decision to *postpone* the decision. Moreover, there is *no* Department *Rule* giving any hint that hospitals should have been prepared at such a "public fact finding inquiry" to give actuarial evidence on *physician* fees or that the "inquiry" should be treated as an adversary proceeding. *Aurora Pump v. Goulds Pumps, Inc.*, 424 So.2d 70 (Fla. 1st DCA 1982) disapproved unwritten or unpublished rules as a basis for determining rights before an administrative body.

(e) The argument does not in any event apply to the 1977 year (nor to any other fund year which is the subject of assessments sought to be levied subsequent to those directly involved in this case). Appellees do not explain and cannot logically justify the failure to set additional fees and at the same time argue that the hospitals are barred from demanding that they do so.

(f) Most important, the state courts rejected all of the estoppel or waiver arguments asserted by Appellees and decided the underlying issues of statutory interpretation and constitutionality. This Court has jurisdiction to review the determination of constitutionality. It should resist the temptation to decide the case on state grounds rejected by the state courts.

II. Response to Points II and III - the Equal Protection and Due Process Issues Are Substantial.

A. Reply to hypothetical justifications for the Statute.

Appellees' series of speculative justifications for the statute as interpreted and applied will not bear scrutiny. The suggestions that hospitals are bigger than doctors or that they usually are corporations do not eliminate constitutional protections. *Prudential Health Care Plan v. Commissioner of Insurance*, 626 S.W.2d 822, 831-33 (Tex. 1981) (imposing increased regulatory fees on corporation violates equal protection).

The argument that hospitals are where physicians engage in most of their malpractice does not rationally make hospitals responsible. The same logic would make the State Road Department responsible for all automobile claims because most accidents occur on roadways; the picture of the hospital administrator looking over the surgeon's shoulder telling him what he is doing wrong is ludicrous.

Speculation that the legislature may have believed that hospitals should pay the burden for physician malpractice because they can control claims through risk management also does not bear up under examination. Although proper risk management is desirable, requiring hospitals to bear physician malpractice costs bears no relationship to a risk management program. It may be theoretically true, although it is not practically true (T. 472-479; 519-526), that hospitals can revoke staff privileges of physicians not complying with risk management programs. *However, revoking staff privileges does not revoke licenses to practice*, and under the statute as interpreted if an expelled physician wants to join the Fund, the hospitals have to pay for his mal-

practice *whether he is on a member hospital's staff or not.* And if it were the legislative reasoning that hospitals should be responsible for doctors' acts, why limit the legislation to hospitals/doctors who happened to be members of the Fund?

Appellees suggest that there is no unfairness because hospitals may really be liable even if they are not sued. They speculate that a physician may be found to be an agent of a hospital, therefore, hospitals ought to be assessed liability for all physicians' claims regardless of whether the hospital is in fact found liable. Not only is this contrary to actuarial requirements—classifications should not be assessed because claims *might* be made when statistically they are not—but it is a reversal of the legal relationship between principal and agent. The agent who is negligent is liable to indemnify his principal, *not* vice versa! The real answer to the appellants' suggested rationale, however, is that the legislature did not make such findings, and the Court should not speculate that it did.

CONCLUSION

For the reasons set forth herein and in the Jurisdictional Statement, the Court should note probable jurisdiction.

Respectfully submitted,

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